Galvanizing Action for Children with Health Complexity in Douglas County: *Steering Committee Meeting*

February 3rd, 2021

Facilitated by the Oregon Pediatric Improvement Partnership (OPIP) with support from The Ford Family Foundation and Local Community Partners on the Steering Committee

Today's Agenda

- Refresher – 50,000 Foot View, Where We Are Now and Focus of Call
- Update from the **Children's Institute** on the Public Documents Summarizing the Douglas County Call to Action for Children with Health Complexity, **Obtain Feedback and Input**
  - Written Summary Document: Key Sections and Areas of Focus and Planned Formatting
  - Video Clip - Mixed format, live and animated narrated video, run time 2-3 minutes.
- Looking Forward – Review Proposed Work Plan and Activities Addressing the Two Priority Theme Areas Confirmed for OPIP to Lead and Support with Community Level Partners, **Obtain Input and Guidance**

#1: Address Capacity of and Child and Family Centered Pathways to Behavioral Health

#2: Increase Community-level Awareness About the Health Complexity Data & Leverage Data

OPIP

Refresher:
Galvanizing Action for Health Complex Children

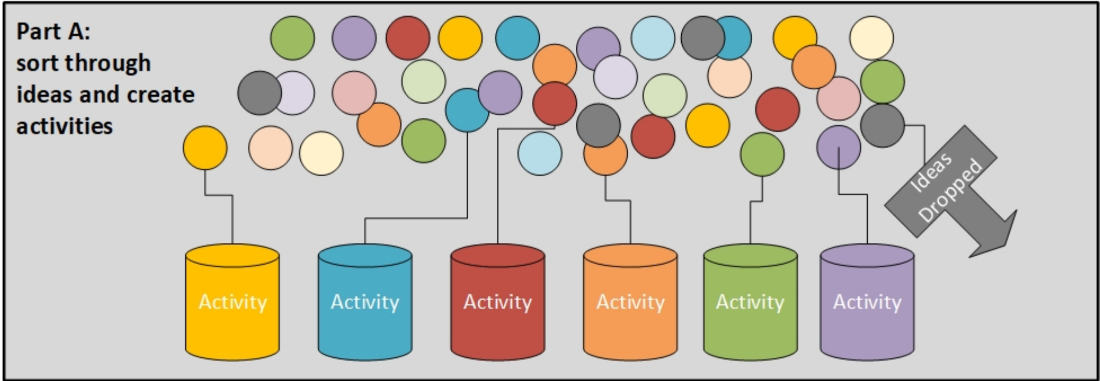
Funder: The Ford Family Foundation

Goal: Support local communities to engage partners, galvanize action and support improvement efforts focused on health complex children.

Target areas to explore: **Douglas County**, Klamath County, Coos/Curry and other Rural Areas

Douglas County Stakeholder Engagement & Commitment

- **Late Fall 2019** meeting of various stakeholders on the data and supports provided to the community
  - Shared consensus and agreement to move forward with a community-level meeting
- **Region-specific steering committee** to guide and inform activities
- **March 3rd Community Level Confirming Call to Action**
  - **Small Group Session to Confirm Design Parameters to Use in Identifying Activities**
  - **Small Group Session to Brainstorm Priority Activities**
  - **Follow-up Survey Completed by Attendees**
- **Engagement of steering committee,** addition of new members from sectors where priority ideas where identified (e.g. early childhood)
  - **Follow-up phone calls** with steering committee members and UHA members
  - **Steering Committee Homework** to Review Proposed Activities within Design Parameters
- **August 20th, 2020 Steering Committee Meeting**
  - Summarized quantitative and qualitative feedback gathered at the meeting, follow-up survey
  - Developed full summary of Call to Action identified based on feedback
  - Review proposed parameters of OPIP would use to determine activities OPIP could support and lead
- **Requested an Extension to FFF grant Given Pandemic, Staffing Needs**
- **November 2020**
  - **OPIP's Reviewed Proposal for Work we can Support and Lead in Next Two Years, Confirmed Two Areas of Priority**
  - **OPIP's Proposal to Collaborate with Children's Institute to Develop a Public Facing Summary of the Call to Action and the Process, Input Obtained**
- **Where we are today!**


Part A:
sort through
ideas and create
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Ideas
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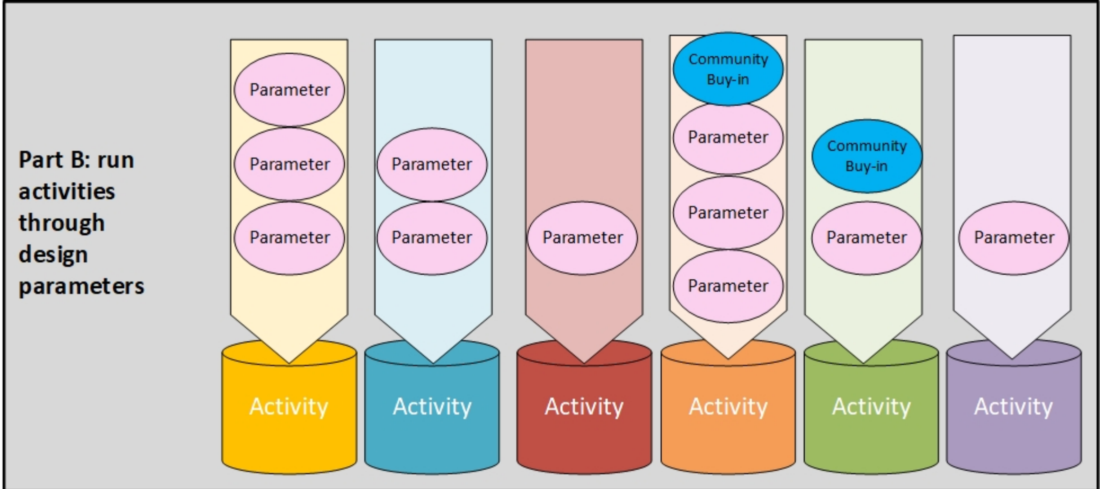
Part B: run
activities
through
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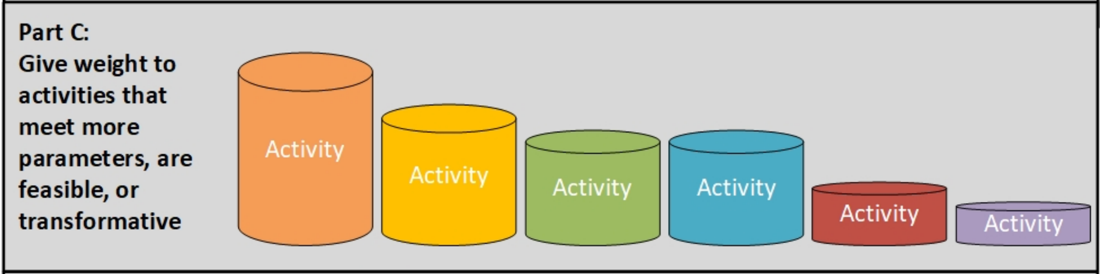
Part C:
Give weight to
activities that
meet more
parameters, are
feasible, or
transformative
Activity
Activity
Activity
Activity
Activity
Activity

Part D:
Sift and
Prioritize
Activitities
Activity
Activity
Activity
Activity
Activities
Sifted Out

The SIFTER: Design Parameters to Use in Identifying Action Activities

- Be able to be **started in the next year**.
- Be **Family-centered & family-informed**, ensuring representation and diversity.
- Be **Provider-informed**, ensuring a diverse front-line provider perspective.
- Be **Trauma-informed** and ensure a focus on **cultural competence**.
- Be focused on **building strengths and resilience** in health complex children and their families.
- Ensure a focus for all children & will **include an intentional focus on health complex children under five.**
- **Align with and leverage priorities** and momentum within:
  - Coordinated Care Organization Priorities
  - Raise Up Oregon for Early Learning
  - Title V Priorities
  - Student Success Act
  - Other local community initiatives such as community health improvement plans, Network of Care, Systems of Care, the Blue Zones project, perinatal task force.
- Prioritize **populations and disparities most impacted by COVID-19 and the state and local government response** (added by OPIP in April 2020)

Pulling It All Together: Priority Areas identified by Each Factor

	# of Activities in Theme	Steering Committee Priority	Design Parameters Overall	CCO Priority Areas
#1: Increase Community-level Awareness	**X**			**1C**
#2: Community Resource Mapping		**X**	**2A,2B**	**2A-2C**
#3: Addressing Barriers to Services	**X**	**X**		**3A**
#4: Train Providers				
#5: Address Capacity in Behavioral Health	**X**	**X**	**5A-5C**	**Globally**
#6: Address Preventive Health and Social Service Needs				
#7: Improve Housing				

OPIP's Proposal for Areas of Focus in Douglas County Call to Action

Factors we considered based on your feedback:

- Parsimony of efforts across Douglas County by other partners to reduce duplicative work (Umpqua Health Alliance, Network of Care, Community Health Improvement Plan, etc)
- Vertical integration of activities to allow for a focused and targeted approach
- Honing in on the topic we heard the most from partners:
  - ❖ Ensuring families and children can access necessary behavioral health supports.

○ Requested a no-cost extension from FFF to support two years of implementation (approved)

OPIP

OPIP's Proposal for Areas of Focus in Douglas County Call to Action

1. **Broad and Deep Work: Address Capacity of and Child and Family Centered Pathways to Behavioral Health**
    - **Community Resource Mapping and Assets, Assessment of Capacity (Track 2)**
    - **Address Barriers to Access of Existing Services within Behavioral Health (Track 3)**
    - **Train Provider on Best Behavioral Health Care for Health Complex Children (Track 4)**

2. **Increase Community-level Awareness About the Health Complexity Data & Leverage Data**
    - **Work with UHA to USE the child-level data to guide and inform their efforts**
    - **Work with Children's Institute to develop communication materials to:**
        - Summarize Call to Action Process and Full Idea Raised in Video, Recorded Format
        - Health Complexity Data and Meaning, Sharing with Community Level Organizations

Update from the Children's Institute on Douglas County Call to Action for Health Complex Children

- Elena Rivera, *Senior Health Policy and Program Advisor*
- Rafael Otto, *Director of Communications*

CI and OPIP Communications Proposal

Goal is to summarize the Douglas County Call to Action for Children with Health Complexity in multiple formats to engage key audiences.

Written document

Video

Children's Institute

Written document

Primary audience: Regional leadership, system leaders, professional stakeholders.

Purpose: Description of the year-long process, the deep community engagement and breadth of stakeholders involved, the priorities identified, the activities and next steps selected.

Format: Designed streamlined narrative with infographic elements, 2-3 pages.

Work samples:
2021 Legislative Agenda
Early Works at Earl Boyles

For Steering Committee:
- Affirm purpose and audience
- Give input on design
- Review draft document and offer input

Children's Institute

Video

Primary audience: Policymakers, general audience.

Purpose: Explain health complexity and why it is an important issue, highlight the community-driven innovative effort leading to the Call to Action, summarize the Call to Action.

Format: Mixed format, live and animated narrated video, run time 2-3 minutes.

Featuring: 2-3 Steering Committee members speaking to the importance of this work from their unique vantage points.

Work samples:
When does learning begin?
Incentive Metrics and Kindergarten Readiness

For Steering Committee:

- Affirm purpose and audience
- Identify steering committee members to feature

Children's Institute

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#2: Increase Community-level Awareness About the Health Complexity Data & Leverage Data

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Track #1: Address Capacity of and Child & Family Centered Pathways to Behavioral Health

Five tracks of Work Proposed by OPIP Aligned with Need & Our Past Experience

1. Facilitate conversations with UHA on how health complexity data can be used to inform, complement and enhance behavioral health intensive care coordination.
2. Assess resources, create an asset map, and support conversations on gaps and building capacity.
3. Facilitate conversations with **families** on barriers to using existing services and ways to build and support existing methods for accessing services through transportation for in-person services and coverage and access to telehealth services
4. Facilitate conversations with **frontline-providers** on barriers to using existing services and ways to build and support existing methods for accessing services through transportation for in-person services and coverage and access to telehealth services
5. **Working with community health care providers** to improve best match referrals and closed loop communication for behavioral health services for children
   - Integrated primary care
   - Specialty behavioral health
   - Other behavioral health providers

Track #1: Address Capacity of and Child & Family Centered Pathways to Behavioral Health

#1: Address Capacity of and Child and Family Centered Pathways to Behavioral Health

❖ In terms of sub-activities, will address about 2/3.

Considerations related to the Population:

- Consider full population (birth to 21)
- **Ensure a specific focus within activities on birth to five (remember this when we think about the social emotional track later)**

Ensure a Family Centered Focus:

- **Parent and youth advisory group** for the improvement efforts
- Focus on recruitment of **socially complex and diverse populations**

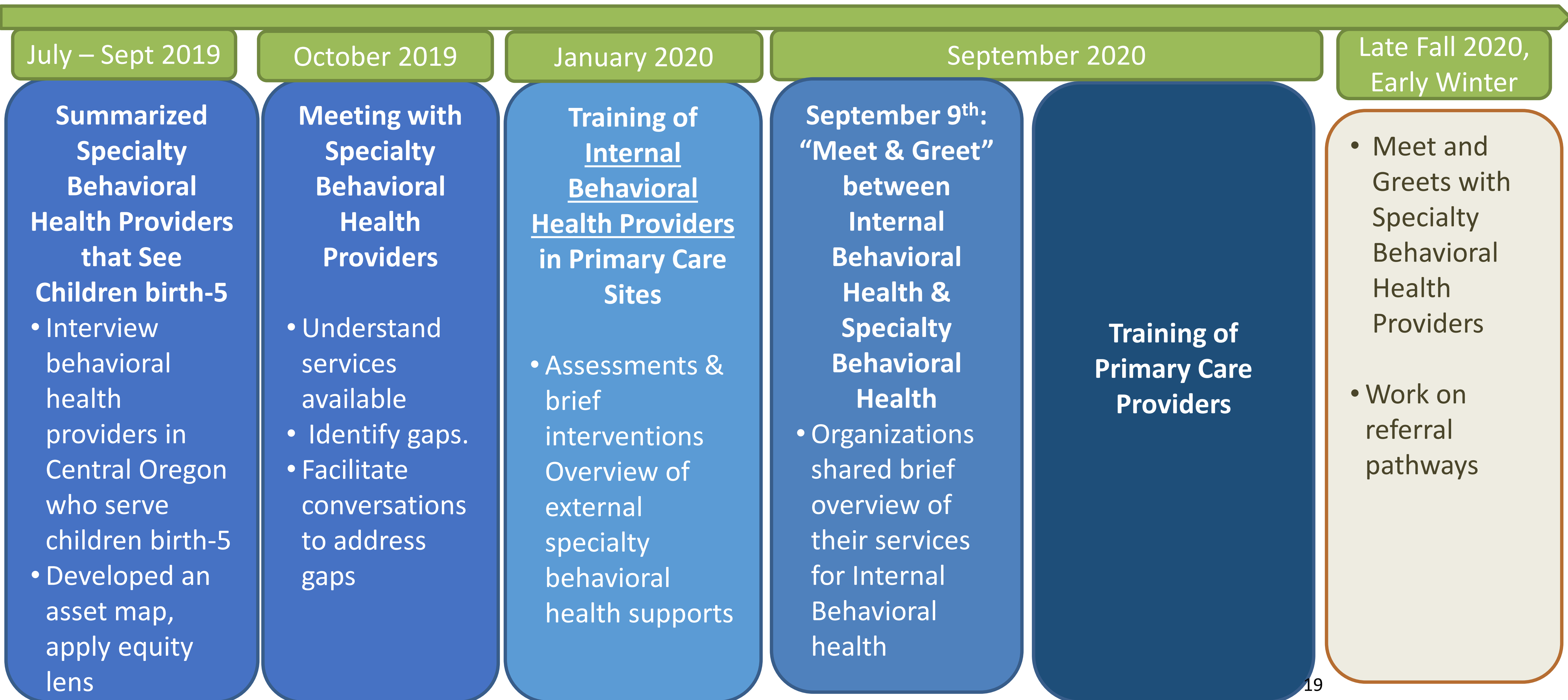
Potential Activity Proposed by Douglas County Community-Level Stakeholder	Whether Activity Addresses Selected Design Parameter							Notes Regarding Community-Level Engagement Needed and Other Considerations
	Whether the Activity Aligns & Leverages Priorities w/in:					Focus on children age 0-5	Prioritizes COVID-19 Impact	
	UHA: Metrics, CLAS, TIC, SDOH, ACEs	Raise Up Oregon	Title V Priority	Student Success Act	Local Community Initiatives			
5. Address Capacity of and Child and Family Centered Pathways to Behavioral Health								
5a. Work with BH entities to understand services available for all children and modalities, and assess gaps relative to capacity. Specific highlight of services for children 0-5.	M?, T, A	X	X	X	X	X	X	• This could be folded into asset / capacity mapping work. • Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric related to social-emotional health. • **Provide Specialty Training in Infant Mental Health or perinatal mood disorder** • **Umpqua Health Alliance currently has a weekly Behavioral Health provider list that is distributed to all providers for capacity/ access for members--addresses specialty services provided** • **Analyze efficacy of current in-home/wraparound services**
5b. Convene community level stakeholders to review and compare existing services with need for services and identify priority areas to address gaps.	M?, C, T, A	X	X	X	X	X	X	• This could be folded into asset and capacity mapping work • Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric related to social-emotional health. • **System of Care is in place currently through Umpqua Health Alliance**
5c. Provide Training on best match behavioral health services for children and adolescents, brief interventions and specialty behavioral health	M?, T, A	X	X	X	X		X	• Considering the buy-in needed and time for training, this may not be feasible during grant period, but could be piloted at certain centers. • Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric related to social-emotional health.
5d. Provide Training on best match behavioral health services for children **specific to young children**	M?, T, A	X	X		?	X	X	• Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric related to social-emotional health.
5e. Support pilots of closed loop referral pathways to specialty behavioral health	M?, T, A		X	X	?		X	• Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric related to social-emotional health. • **Currently UHA has MOU in place with Education Service District-Community UpLift for referrals for ages 0-21.**
5f. Support pilots of closed loop referral pathways to specialty behavioral health **specific to young children**	M?, T, A	X			?	X	X	• Relates to proposed future Health Aspects of Kindergarten Readiness metric focused on a system-level metric relate • **Currently UHA has MOU in place with Education Service District-Community UpLift for 0-21.**

Pathways from Developmental Screening to Services Project: Ensuring Young Children Identified At-risk Receive Best Match Follow-up

Examples from Another Region of Deep Work OPIP Led:

- **Asset mapping in the community of behavioral health services**
  - Develop a framework specific to the services for young children and applying and equity lens
  - Significant gaps in services identified, October meeting
  - Supports to community in addressing gaps, individual meetings with seven organization on how to build capacity
  - Updating the asset map three times
  - Multiple rounds of interviews with each of the 19 providers
  - Development of robust compendium that included information about services
- **Referral to Developmental Evaluation**
  - Who to refer
  - Family centered referral pathways
  - Advocacy for a position
  - Addressing hiccups, frustrations, changes in process
- **Meet and greet meeting between behavioral health and PCPs**
- **Training materials for PCPs that incorporated this**

Overview of Work with Specialty Behavioral Health Providers



Early Learning & Wellness LAST A LIFETIME EARLY LEARNING HUB OF CENTRAL OREGON

Objectives of Training with Primary Care Pilot Sites on Social Emotional Pathways

OPIP

By the end of today's training we hope you have a better understanding of:

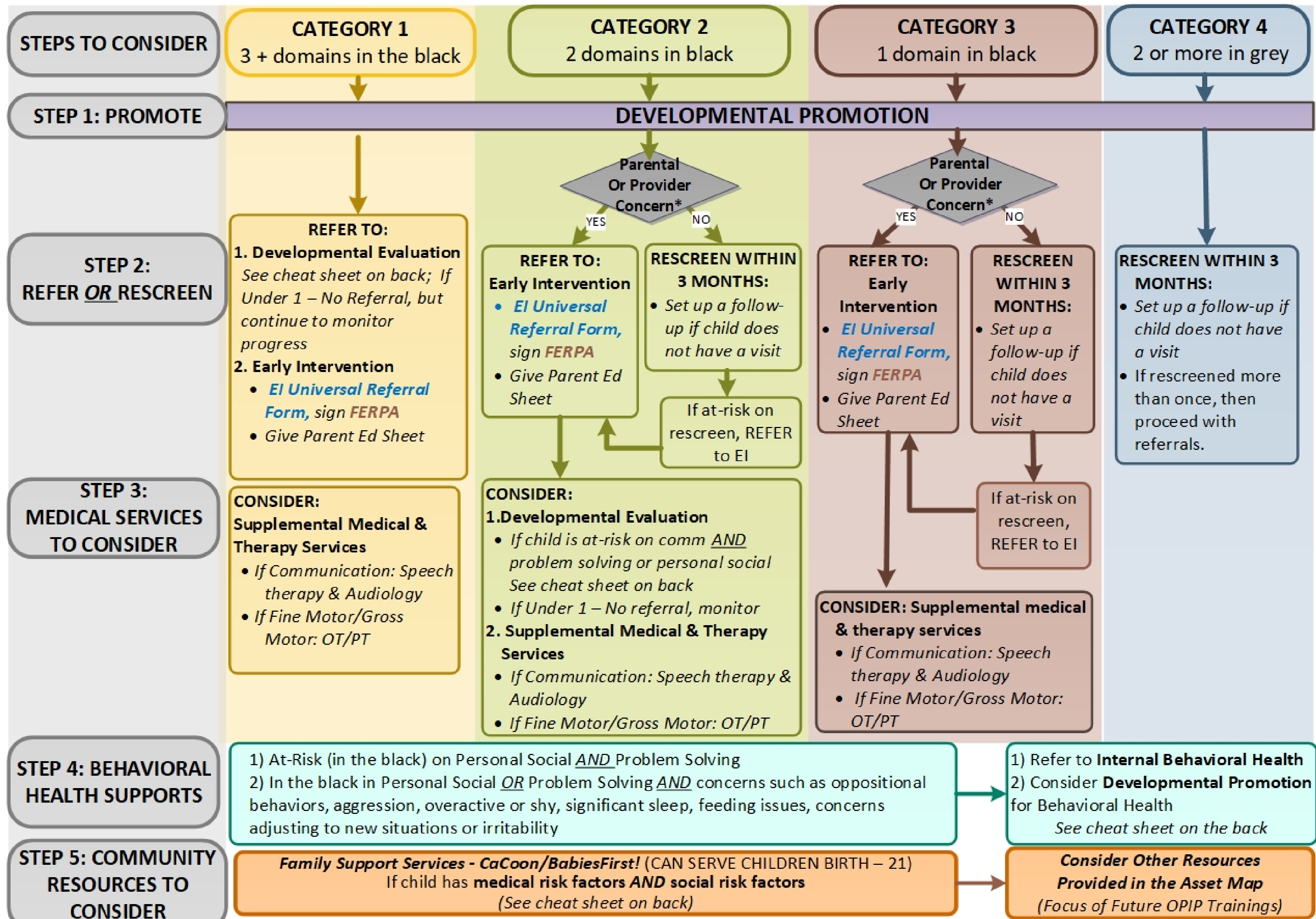
1. What **social emotional development** for young children birth to five looks like and **how to use screening tools you are already using** in well-care (ASQ, M-CHAT and Maternal Depression) to identify potential delays in social emotional health
2. Opportunities to **engage families in developmental promotion and referral(s) to Internal Behavioral Health**
3. **Training provided to Internal Behavioral Health providers** on "next steps" they can take and what your patients may experience with IBH
4. **Understand what Specialty Behavioral Health services exist** in Central Oregon and the types of modalities provided that could best serve families with children birth to five

Booster on Social Emotional Health for Birth to Five

OPIP

1. **What is Social Emotional Health for Children Birth to Five?**
2. **Who** to Send to Internal Behavioral Health Services
3. **How to Engage Family in Services**
   - Talking point for providers
   - Developmental promotion materials to consider
4. **Integrated Behavioral Health**
   - Brief assessments
   - Brief interventions
   - Identifying children to refer to Specialty Behavioral Health
5. **What Specialty Behavioral Health Services Exist in Central Oregon**
   - Compendium Created

OPIP's Medical Decision Tree based on Best Match Follow Up for Developmental screening



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BEHAVIORAL HEALTH SUPPORTS: CHEAT SHEET

If child is "in black"
Personal Social & Problem Solving

OR

If child is "in black" on
Personal Social OR Problem Solving

+

Concerns such as oppositional, aggressive, overactive or shy/ anxious behaviors, significant sleep, feeding, self-soothing, adjusting to new situations, or irritability concerns

OR

Exposure to Adverse Childhood Experiences (ACES) in Family Environment
https://acestoohigh.com/got-your-ace-score/

1) REFER To Internal Behavioral Health

- **Additional assessments of child's development, parental factors**
- **Brief parent/child therapies**

2) Consider Developmental Promotion specific to Behavioral Health

If additional supports are needed:

- **Engage family in behavioral health referral**

Referral to Specialty Behavioral Health Services
(see compendium on Behavioral Health Assets)

Ecology of Social-Emotional Delays

Important to recognize **multiple determinants** and social-ecological contributors leading to behavior concerns:

Social Ecology:
- Marital Conflict/Divorce
- Maternal Social Isolation
- Aversive Extended Family
- Low Control Neighborhood
- Poverty/Crime

Child Characteristics
- Negative Temperament
- Emotional Dysregulation or Mood Disorder
- Hyperactive-Impulsive

Parent Characteristics
- Adult ADHD
- Depression/ Mood Disorder
- Early Child-Bearing/ Single Unemployed
- Substance Dependence/Abuse
- Illness (medical/psychiatric)

Disrupted Parenting
- Maternal Social Isolation
- Aversive Extended Family
- Low Control Neighborhood
- Poverty/Crime

The four factor model of child oppositional defiant behavior. From R. A. Barkley (2013). Defiant Children: A Clinician's Manual for Assessment and Parent Training (3rd ed.). New York: Guilford Press. Copyright 2013 by the Guilford Press.

Riley, A; (2020) . Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up; Internal Behavioral Health Training. [PowerPoint presentation] Bend, OR.

BEHAVIORAL HEALTH SUPPORTS: CHEAT SHEET

If child is "in black" **Personal Social & Problem Solving**

OR

If child is "in black" on **Personal Social OR Problem Solving**

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Referral to Specialty Behavioral Health Services

(see compendium on Behavioral Health Assets)

Tools Provided to Integrated Behavioral Health

a. **Secondary assessments and clinical decision making framework:**
    1) Conceptual framework for determining risk
    2) Available assessment strategies
    3) Profiles of risk

b. **Intervention strategies for impacting early childhood social-emotional delays:**
    1) Low-intensity intervention resources
    2) Research-based primary care therapies
    3) Adapting evidence-based therapies

c. **Billing Strategies**

Compendium Summarizes Services By:

OPIP

1) **Type of social-emotional delays or factors the service targets**

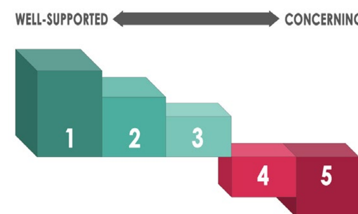
– If the goal is to get kids in to the right "best match" services, what are the best services for specific factors the pilot sites and project will focus on

2) Delivery method

– Dyadic or group

– Can be factor in considering parent engagement

3) Scientific Rating - Evidence Base for Various Modalities:



Behavioral Health Services for Children Under Five with Social Emotional Delays

Selected Parent-Child Programs for Children Under 5 with a Scientific Rating of 1-3 Focused on (1) Positive parenting, (2) Effective limit setting and safe discipline, and (3)Child-parent relationship building

Therapy/Program Name	Delivery Method[1]	Age of Child	Scientific Rating
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS			
Parent Child Interaction Therapy (PCIT)* ** PCIT is also an effective program for children with known trauma history*	Dyadic	1-7	1
Generation-PMTO	Dyadic, Family & Group	2-18	1
Triple P (Positive Parenting Program)	Group	0-12	2
Theraplay	Dyadic	0-18	3
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)			
Collaborative Problem Solving	Family, Individual	3-21	2
Play Therapy	Family, Individual	3-12	3
Helping the Non-compliant Child	Dyadic	3-8	3
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY			
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2
Eye Movement Desensitization and Reprocessing (EMDR)	Individual	2-17	1**
Attachment Regulation and Competency (ARC)	Dyadic, Family, Individual	0-21	Not rated
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED CHILDREN UNDER 3)			
Trauma Focused CBT	Dyadic	3-18	1
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES			
Family Check-Up	Dyadic	2-17	1
Attachment and Biobehavioral Catch-up (ABC)	Dyadic	0-2	1
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED CHILDREN UNDER 3)			
Incredible Years* ** Incredible Years is also good for children with disruptive behavior problems*	Group	4-8	1

1 Dyadic therapies are those done with the parent and the child together. Group therapies can be group-level classes delivered to a group of parents without children present, or delivered to a group of families with both children and caregivers present.
**None of the evidence used to rate EMDR was conducted on children under 4 years of age

Developed by the Oregon Pediatric Improvement Partnership based on literature and evidence review summaries and consultation from Andrew Riley and Laurie Theodorou. For more information about these modalities, https://www.cebc4cw.org/ provides a comprehensive overview.

Draft Version 15 September 10, 2020	Current Assessment of Specialty Mental Health Providers Who See Children Birth-5 in Central Oregon															
	County in Which the Services are Available															
	Deschutes						Deschutes & Crook		Crook		Jefferson	All Counties	Home Visits Across All Counties			
Company	Deschutes County	Cherie Skillings	Life Source Therapy	Starfish Counseling	The Child Center	Treehouse Therapies	Forever Family Therapy	Rimrock Trails	Crook County BestCare	Prineville Counseling Center	Jefferson County BestCare	Brightways Counseling	Amy Bordelon, LMFT	Now and Zen	Blossom Therapeutic Collective: Saul Behavioral	Youth Villages
Office Location	Redmond (7) Bend (6) LaPine (2)	Bend	Redmond	Bend	Bend, La Pine, Redmond	Bend, Redmond	Bend, Prineville	Bend , Redmond & Prineville	Prineville	Prineville	Madras	Redmond (3), Madras (2), Prineville (1)	Bend	Redmond & Sisters	Bend	Redmond
# of Providers	15	1	1	1	10	3	4	4	3	2	3	6	1	1	2	6
Case Load (per week)	114	24	30	25	134	51	40	75	*	40	*	160	12 families + 9 groups	30	30	24
Capacity for New referrals	25 families	12 families	Limited	At Capacity	At Capacity	17 families	16 families	40 families	6 families	4 families	20 families	45 families	Limited	3-5 families	1-2 families	2 families
Provider Race, Ethnicity	14 White, 1 White/ Hispanic,	White	White	White	White	White	3 White, 1 African American	White	White	White	White	White	White	White	1 White	1 Japanese-American, 5 White
Provider Language Spoken	14 English, 1 Spanish/ English	English	English	English	8 English, 2 Spanish/ English	English	English	3 English, 1 Spanish	English	English	English	English	English	English	English	English
Payer	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP	OHP	OHP/ Private	OHP/ Private	OHP/Private	Private/ Sliding scale	OHP/ Private	Patient submits claims	OHP/ Private
Tele-services	Yes	Yes	*	*	*	Yes	Yes	1 nurse practioner	Yes, during COVID-19	*	Yes, during COVID-19	Yes	*	*	Yes, and in CA, FL, NC	*

Need follow up Interviews with: IHS Warm Springs; Do Not see Children ages Birth-5: Lutheran Community Services, Bend; Cascade Child and Family Center

*	Information needs to be verified
(hatched)	Only takes referrals for children/families that are at risk for out of home placement. Won't count towards capacity.

Compendium of Behavioral Health Services for Birth to Five in Central Oregon

Date Last Updated: 8/13/2020

Behavioral Health Services for Children Birth to Five in Central Oregon

Overview and Purpose

The Early Learning Hub of Central Oregon and the Oregon Pediatric Improvement Partnership (OPIP) are leading an effort called the "*The Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up Meant to Prepare for Them Kindergarten*". The project is funded by the Central Oregon Health Council and the Early Learning Hub of Central Oregon.

A component of this work is focused on best match follow-up services for children identified with developmental, behavioral and/or social emotional delays. Stakeholder interviews indicated a need for **summary of the available specialty mental health services** available for children birth-to-five, descriptions of the specific modalities offered, and information about the providers serving young children and their families in the region. Over the last year, OPIP has interviewed and conducted an in-person meeting to understand the current available resources. This summary is the synthesis of those interviews and the information provided as of August 2020. Given this is an evolving landscape, OPIP will update this document in Spring 2021 before the conclusion of the project.

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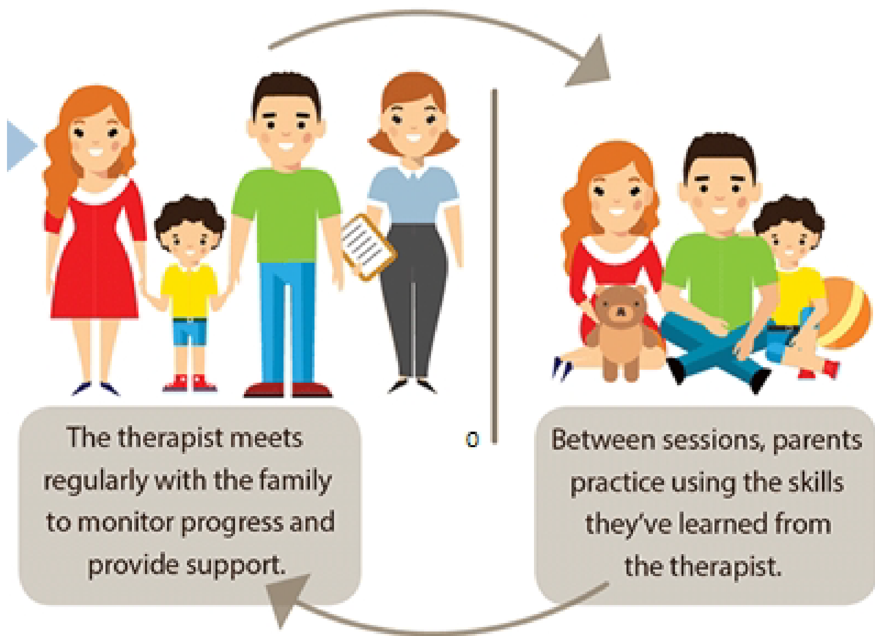
Parent Education to Support Shared Decision Making and Engage Family in External Referral

What Parents Can Expect

With the support of behavioral health providers, parents can learn skills to help improve their child's behavior, leading to improved functioning at home, school and in relationships.

Parents typically attend 8 or more sessions with a therapist. Sessions may involve groups or individual families. Learning and practicing behavior therapy requires time and effort, but it has lasting benefits for the child.



After therapy ends, families continue to experience improved behavior and reduced stress.

What Parents will Learn

Positive Communication

Positive Reinforcement

Structure

Behavior therapy, given by parents, teaches children to better control their own behavior, leading to improved functioning at school, home and in relationships. Learning and practicing behavior therapy requires time and effort, but it has lasting benefits for the child.

Materials and graphics adapted from CDC Vital Signs parent education sheet: https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html

Health Aspects of Kindergarten Readiness

- Statewide effort led by Children Institute, OPIP and Oregon Health Authority
- Leading implementation of a four part measurement strategy to be adopted as a Coordinated Care Organization (CCO) Incentive Metric Set
- Two of the metrics adopted last year
  - Well-Child Visits 3-6
  - Oral Health 1-5
- CI and OPIP Leading Development and Proposal for 3rd metric for Proposed Adoption in 2022
  - System-Level Social Emotional Metric

OPIP

Health Aspects of Kindergarten Readiness Measurement Strategy Proposal

Stratification and reporting of metrics to examine disparities and for CYSHCN

Preventive Dental Visits for Children 1-5

- Data source: Claims.
- HAKR domain: Promotion/prevention.
- Mean score on HAKR measure criteria: 10.8 (out of 13)

Well-Child Visits for Children 3-6

- Data source: Claims.
- HAKR domain: Promotion/prevention.
- Mean score on HAKR measure criteria: 8.62 (out of 13)

CCO-Level Metric Focused on Social-Emotional Health

(To be developed)

- Data and information provided by the CCO.
- HAKR domain: Promotion/prevention, Follow-up, and CCO cross-sector collaboration.

Potential components:

- Screen for and identify factors that impact social-emotional health.
- Assess capacity and utilization of behavioral health services.
- Address policies and payment for behavioral health services.

Follow-Up to Developmental Screening*

(Existing practice-level metric to be adapted for a CCO metric; proposed to replace developmental screening metric)

- Data source: EHR.
- HAKR domain: Follow-up.
- Mean score on HAKR measure criteria: 11.5 (out of 13).

(Future) Child-Level Metric Focused on Social-Emotional Health

(To be developed, informed by CCO-level metric)

Potential examples:

- Screening for social-emotional health.
- Screening for social determinants of health and family factors impacting social-emotional health.
- Preventive care bundled metric.
- Dyadic behavioral health services for children 0–6.
- Metric(s) for children and youth with special health care needs.

GOAL

Health system behavior change, investments, and cross-sector efforts that contribute to improved kindergarten readiness.

Estimated Year Metrics Ready for Implementation

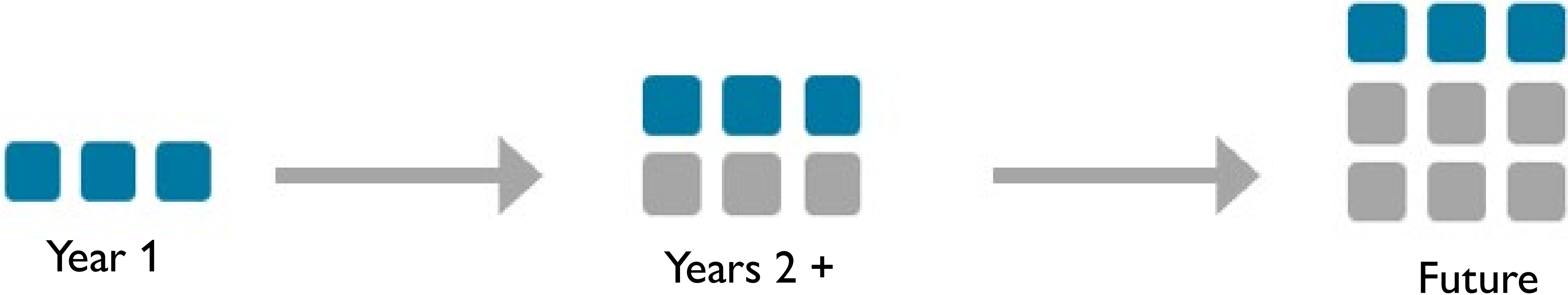
Support for measurement strategy and for new System-Level Social-Emotional Health Metric

- **September 2018:** Health Aspects of Kindergarten Readiness Technical Workgroup endorses System-Level Social-Emotional Health Metric to be included in four-part measurement strategy recommendations.
- **November 2018:** Metrics and Scoring Committee unanimously endorses Health Aspects of Kindergarten Readiness four-part measurement strategy.
- **January 2019:** Health Plan Quality Metrics Committee endorses four-part measurement strategy, including signaling go-ahead to develop new System-Level Social-Emotional Health Metric.
- **2019-2020:** Oregon Pediatric Improvement Partnership, Children's Institute, and Oregon Health Authority develop draft metric components based on extensive learnings from improvement pilots and stakeholder feedback.
- **November 2020**: Metrics and Scoring reviewed measure progress to date and strongly supports moving into the pilot phase to broaden testing base and collect data to assess feasibility, reliability, and validity.

Creating a solid foundation for kindergarten readiness

Vision:

Children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs.



Use claims + utilization data to understand current access to behavioral health services for young children.

Assess community assets that support social emotional health for young children.

In later years CCOs will address the barriers identified in earlier years by attesting to specific interventions in areas such as:

- ✓ Community engagement
- ✓ Workforce
- ✓ Access
- ✓ Care coordination
- ✓ Payment

Child-level metric focused on improving equitable receipt of social-emotional health services

Pilot Goals

- Gain CCO input on the components of the CCO System-Level Social-Emotional Health Metric to ensure clarity and that items are feasible, reliable, and valid in galvanizing meaningful action.
  - Part 1.1: Social-Emotional Health Reach Metric (Child level data provided by OHA to CCOs)
  - Part 1.2: Social-Emotional Health Attestation
- Assess feasibility, reliability, and validity of data collection tools within the attestation metric.
- Support CCOs to gain familiarity with the metric and build awareness and readiness for future metric implementation, pending adoption.

Pilot Activities

Pilot activities will take place in February – Early April 2021. CCOs will be engaged through group webinars and individual close-out calls.

Specific activities will include:

- *Review Social-Emotional Health Reach Metric data* from the Oregon Health Authority. Analyze, interpret, and offer input on implications of data.
- *Review and offer input on templates* and processes proposed for inclusion in the *attestation metric* that relate to understanding available services.
  - Tools to support development of an asset map of services available to address social-emotional delays and identifying gaps in services compared to need.
  - Ensuring a strong health equity informed approach
- Review and offer input on templates describing community-level *partners engaged and learnings.*
- Review and offer input on templates describing learnings about *barriers to connection and access of services* with a focus on vulnerable and historically underserved populations.

Pilot Activities: Data from OHA

- OHA will provide each CCO an aggregate report of:
  - Reach metrics findings overall
  - Reach metric findings by whether assessment, services or both
  - Reach metric findings by health complexity categories, including specific social complexity factors (depending on factor and sample size, some cells may need to be suppressed)
- OHA will also provide each CCO their child-level data file:
  - Reach metric findings overall
  - Reach metric findings by each category of assessment and service codes

UHA Participation in SE Emotional Pilot

- UHA signed up for the pilot on 2/2/21
- Work within pilot aligned with Track #1 goals for birth to five.
- Great starting point and action steps for early 2021.

Input Needed on Track #1: Address Capacity of and Child & Family Centered Pathways to Behavioral Health

- What excites you about this proposed work?
- What questions do you have? Areas you wished you saw that you didn’t?
- These activities were aligned with a number of efforts.
  - How do we coordinate and be synergistic?
- How do we partner with you to recruit parents and youth for the advisory group?
- Who should we connect with to interview and understand provider perspective?
- OPIP has a Behavioral Health Improvement Facilitator Position Open
  - Should we consider opportunities to partner with someone from Southern Oregon broadly? In the region?

#2: Increase Community-level Awareness About the Health Complexity Data & Leverage Data

Two Tracks of Work

1. CI work described earlier
2. Work with UHA to USE the child-level data to guide and inform their efforts related to their CCO priority tracks (2020 and 2021 Data)

OPIP

OPIP's Proposal for Areas of Focus in Douglas County Call to Action

#2: Increase Community-level Awareness About the Health Complexity Data & Leverage Data

Work with UHA to USE the child-level data to guide and inform their efforts

- **Analyze applicable quality metrics BY the health complexity** to inform root cause drivers of gaps in care and inform better targeting to improve the metrics.
- Analyze the **health complexity data by zip code** and **by school district** within Douglas County to inform the Network of Care work and identify areas where there are large needs and then to compare those needs with available resources in that zip code or school district.
- Analyze the **data by PCPCH** in order to consider trauma-informed trainings or follow-up steps to ACEs for practices that serve patients with high health complexity rates.

OPIP

Parameter Related to CCO Alignment

- For the Coordinated Care Organization (CCO) priorities, OPIP anchored to the five priority areas outlined by Umpqua Health Alliance (UHA) that they are investing efforts that relate to the following:

1. Metrics as defined by the metrics included in Health Plan Quality Metrics and in the Incentive Metric set (metrics),
2. activities related to Social Determinants of Health (SDOH) – which include screening and creating a dashboard of data to guide activities,
3. Trauma Informed Care (TIC),
4. Culturally and Linguistically Appropriate Services (CLAS), and
5. Addressing Adverse Childhood Events (ACES).

FFF Elements Related to USE of Data

Potential Activity Proposed by Douglas County Community-Level Stakeholder	Whether Activity Addresses Selected Design Parameter							Notes Regarding Community-Level Engagement Needed and Other Considerations
	Whether the Activity is Aligned with and Leverages Priorities within:					Focus on children age 0-5	Prioritizes COVID-19 Impact	
	UHA Priorities: *Metrics, CLAS, TIC, SDOH, ACEs*	Raise Up Oregon	Title V Priority	Student Success Act	Local Community Initiatives			
1. Increase Community-level Awareness About the Health Complexity Data & Leverage Data to Identify Needs								
1a. Develop a region-specific public campaign & report that provides the data paired with stories from families about strength, resilience and needs.	**T, S, A**				**X**	**X**	**X**	• Are there community partners with communication experience that should be leveraged? • Are there specific groups we should target or make sure we include? • Are there specific groups we should target or make sure we include • **The Perinatal Task Force has a health equity work group that may be interested in supporting this campaign.** • **This activity aligns with Network of Care**
1b. Analyze the data by zip code and break out the data by regions or school districts within Douglas County.	**S, A**				**X**	**X**	**X**	• **Aligns with priorities noted by Umpqua Health Alliance staff** • **It would be interesting to combine the data with the stories from families (1a) & services available for the regional/community view.** • **Network of Care is working on this**
1c. Analyze tracking and incentive metrics by health complexity factors and within region.	**M, T, S, A**				**X**			• **Aligns with priorities noted by Umpqua Health Alliance staff**
1d. Incorporate use of the data in CHA and CHIPs.	**T, S, A**				**X**			• What is the status of combining community health plans? Who would need to be engaged? – **Network of Care is combining and needs to be engaged**

THANK
YOU